SOCIAL PLANNING
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A SUBMISSION TO THE STANDING COMMITTEE ON SOCIAL DEVELOPMENT REGARDING BILL 94 THE HEALTH CARE ACCESSIBILITY ACT

by

The Social Planning Council
of Metropolitan Toronto

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Introduction

The Social Planning Council of Metropolitan Toronto welcomes the opportunity to comment on Bill 94, the Health Care Accessibility Act, through this presentation before the Standing Committee on Social Development. As a member organization of the Ontario Health Coalition, the Council has repeatedly affirmed its commitment to the five core principles of Canada's medicare system: 1) Universality of coverage; 2) Comprehensiveness of insured services; 3) Accessibility on the basis of uniform terms and conditions; 4) Portability; and 5) Non-profit public administration.

The Honourable Emmett M. Hall in his report, Canada's National-Provincial Health Program For The 1980's, rejected the concept of extra-billing as violating the essential principle of accessibility that would, in time, lead to a two-tier system of medical care incompatible with a universal, publicly-funded health insurance program. The Social Planning Council concurs in this view and strongly supports the thrust of the proposed legislation.

In introducing Bill 94, the Ontario government has brought forward legislation which will meet the accessibility and universality provisions of the Canada Health Act. In following in the footsteps of seven other provincial jurisdictions, Ontario stands to recoup about $90 million in foregone federal revenues, monies urgently needed to support expanded community-based health programs.

The Social Planning Council is deeply concerned by the potentially destruc-

tive, confrontational situation which has emerged over the course of the last few months between the government and the leadership of the medical profession. Every effort should be made to avoid the kind of bitterness which led to the doctors' strike in Saskatchewan during the 1960s. Maintaining the quality of our health care system depends in part on the atmosphere of trust and confidence that exists between patient and doctor and on the morale within the medical profession.

In seeking a responsible and equitable compromise, both sides must be prepared to make concessions. For its part, the government must recognize that the medical profession is unlikely to willingly give up the right to extra-bill without any discussion in the legislation of an impartial, publicly accountable means of resolving disputes regarding the negotiation of fee schedules. On the other hand, the medical profession must accept that extra-billing by physicians is simply not consistent with the provision of medical services through a universal insurance program based on the principle of equality of access.

The Right to Health Care

It is twenty years since the passage of the Medicare Act. The public has come to view access to quality, comprehensive medical services as a basic entitlement of citizenship much like public education. As Justice Hall put it in his 1980 report to Health and Welfare Canada:

> "The Canadian people determined that they should band together to pay medical bills and hospital bills when they were well and income-earning. Health services were no longer items to be bought off the shelf and paid for at the check-out stand."[1]

Simple economics dictates that extra-billing undermines this concept and contributes to the development of two-tier medicine. If the same good is sold in the marketplace at two different prices, customers will flock to the place where the good is cheaper. This means lineups for those seeking cheaper service and quick attention for those willing and able to pay the higher rate. It means public clinics for some, and private office consultations for others. This is the route that medicare has rightly rejected.

Extra-Billing Threatens Accessibility

Research in Canada has documented that physician extra-billing and other direct patient charges act as a deterrent to the use of health services by imposing a financial barrier. In Saskatchewan, user fees contributed toward an 18 per cent decline in physician visits by the poor and elderly between 1968 and 1972. The Stoddard and Woodward study conducted in Ontario for Justice Hall in 1980 found that nearly 20 per cent of respondents had reduced physician visits, and nearly 5 per cent had not sought care for a sick child as a result of extra-billing. The study also found that the poor, including the elderly, were significantly more likely than the non-poor to reduce visits and/or delay seeking care due to extra-billing.[2]

In Ontario only about 1 in 8 doctors currently extra-bill, but this proportion is much greater among certain highly-paid specialists and in particular geographic locations. For example, while the rate of extra-billing among general practitioners and family physicians is 4.6 per cent, it is 58.3 per cent in anesthesiology, 39.5 per cent in opthalmology, 37.6 per cent in urology, 33.8 per cent in obstetrics and gynaecology, 30.1 per cent

in orthopedics, and 27.6 per cent in psychiatry. It also varies considerably by geographic area, from a high of 30.3 per cent for medical specialists in the Toronto area, to a low of 4.2 per cent in northwestern Ontario.[3]

Evidence from seniors and social welfare organizations document telling examples of the financial hardships faced by low-income households as a result of being extra-billed. Studies in Alberta and Ontario have concluded that low-income households are routinely extra-billed. The Alberta Medical Association conducted its own study in 1985 and was surprised to find that 800 Alberta physicians had extra-billed patients on welfare.[4]

Extra-billing amounts to an additional tax on the sick at a time when they are most vulnerable and least able to cope. It increases health care costs without providing any measurable benefit in terms of quality of care or more efficient use of health services. In restoring the notion of means testing and charity medicine, it puts patients in the position of pleading poverty to avoid additional charges. Extra-billing is a residual anachronism from the era of medicine which predates the introduction of medicare; it has no place in the health care system of the 1980's and 1990's.

Responding To Physician's Concerns

In voicing their opposition to Bill 94, the Ontario Medical Association (OMA) has raised a number of concerns, not all of which are related directly to physician extra-billing, but nonetheless deserve serious dis-

cussion. These issues include: 1) rewarding exellence, 2) professional independence, and 3) underfunding within the health care system.

Rewarding Excellence

The OMA makes the claim that banning extra-billing will remove the principal method which exists to reward excellence in physicians. Even a cursory review of the incidence and distribution of extra-billing negates this argument. As noted previously, extra-billing is heavily concentrated in certain medical specialties and geographic areas. Each individual physician makes the decision to extra-bill without reference to any process of peer review. The only requirement is a willingness to risk imposing a financial burden on one's patients.

While extra-billing does not serve as a means of rewarding excellence, the issue itself is worthy of fuller examination. Ironically, it has been the medical profession rather than the government which has demonstrated a continuing reluctance to act on this matter in the past. The OMA list of fees has existed since 1922 and has never included adjustments based on merit or expertise. Since 1971, while the OMA and the Ontario government have negotiated the mean level of fee increases within the Ontario Health Insurance Plan, the OMA alone has decided how these increases are divided among physicians.

A related issue is the distribution of fee schedule increases among physicians. Recent figures from the Ministry of Health indicate that the average income of general practitioners and family physicians declined more than 6 per cent relative to medical specialists between 1980/81 and

1985/86. General practitioners now earn less than 65 per cent of a specialist's income.

The Social Planning Council believes that OHIP can and should encourage excellence in physicians. It should also address the widening disparity in incomes between doctors in general practice and medical specialists. We note that increases within the negotiated fee schedule have consistently exceeded the inflation rate in recent years, including a 4 per cent increase in January of this year. A further negotiated increase is expected in April.

The recent overall level of fee increases provide sufficient flexibility to address these inequities within the fee schedule. While the administering of fee adjustments should remain the sole responsibility of the medical profession, the provincial government must exercise some role in establishing the criteria for allocating funds designed to reduce inequities and reward excellence.

Professional Independence

A charge frequently made by medical practitioners in recent weeks has been that banning extra-billing represents a serious infringement of the physician's right to operate as an independent professional entrepreneur. More extreme statements have claimed that doctors will become civil servants once bill 94 is declared as law. There is more rhetoric than reality behind these assessments.

To purport that doctors have the right to set their own fees without reference to any considerations beyond the economics of the market place is inappropriate and betrays a grave misconception about the nature and operation of our present health care system. As Justice Hall put it in 1965:

> "Organized medicine is a statutory creation of legislatures and of parliament. When the state grants a monopoly to an exclusive group to render an indispensable service it automatically becomes involved in whether those services are available and on what terms and conditions."[5]

It is now twenty years since we as a society decided that health care was an essential service and put in place the means of ensuring equality of access to necessary medical care as a basic social right. In addition to safeguarding the population at large from the financial risks associated with illness, the introduction of a universal, publicly-funded health care system contains many benefits for physicians, including:

- guaranteed payment for 100 per cent of any fees billed through the Ontario Health Insurance Plan;
- the provision of well equippped hospitals and skilled health workers to assist them in the care of their patients; and
- freedom from the financial costs of administering fee payments and elimination of bad debts and uncollectable bills

The public as taxpayers fund the provision of hospital support services, nursing care, diagnostic equipment and laboratory tests, and hospital beds. In addition, the public shoulders about 90 per cent of the cost of physician's training, which can exceed $100,000 per physician.

Bill 94 will unquestionably limit the freedom of physicians to extra bill patients for insured health services for which payment in full is already provided through a negotiated fee schedule. Such a limitation, accessibility arguments aside, would appear to represent a fair and reasonable trade-off when measured against the many benefits to physicians cited above.

Our publicly-funded medicare system, with or without extra-billing, grants physicians extraordinary autonomy in the delivery of health services. They act as the gatekeepers to the system, determining who will be admitted to hospitals, chronic care facilities and homes for special care. Physicians control their patients length of stay as well as the kinds of treatments and diagnostic tests which are necessary. In addition, a large number of patient visits to physicians are generated by doctors recalling and referring patients.

A study by Wolfson and Tuohy for the Ontario Economic Council in 1980 found no significant differences between opted-in and opted-out physicians in terms of patient loads, hours of work, waiting time for appointments, or any other important dimension of a physician's practice.[6] All in all, there is little or no evidence to support the contention that eliminating extra-billing poses a serious threat to professional independence.

Underfunding the Health System

The OMA has asked that Bill 94 be withdrawn until such time as a thorough review of accessibility and funding problems within the health care

delivery system can be carried out. The Social Planning Council concurs with the need to look at accessibility problems caused by the inadequacy of system resources to meet particular patient needs in a given setting. We reject the notion that Bill 94 should be delayed until such a review has taken place.

The question of underfunding within the health care system is a complex one, and largely beyond the scope of our remarks today. Nonetheless, we feel it is important to make a number of broad observations. Excluding payments on the public debt, the Ministry of Health now accounts for nearly 36 per cent of total government spending. During the last decade, the proportion of budgetary expenditure consumed by the Ministry of Health has grown nearly 20 per cent. Since 1975, payments to physicians have grown from 7.5 per cent of government spending to 10.5 per cent, an increase of 40 per cent.

The Social Planning Council believes that the health care system must continue to be adequately funded to ensure that the people of Ontario have access to comprehensive, high quality health services. However, we are not convinced that problems within the system are primarily due to overall underfunding. Many of these problems result from decisions about the allocation of resources among different elements of the system.

We have developed a health delivery system in Ontario which is heavily weighted toward institutional care and treatment. Less than 3 per cent of the total health budget is directed toward preventive community-based approaches which, over the long-term, can reduce health costs by limiting our reliance on chronic care institutions. Failure to devise adequate

community-based health programs, particularly for the elderly, has contributed to a rapid escalation in the need for chronic care beds. This in turn is creating serious problems in many public hospitals where acute care beds are taken up by patients awaiting access to a chronic care facility.

Adequate Compensation For Physicians

Table 1 reviews the extent to which payments to physicians under OHIP have maintained their value in comparison to other fee schedules and changes in the cost of living. With the exception of the 1971 to 1975 period, the data suggests that the OHIP fee schedule has generally maintained a reasonable relationship to both the dental association's fee schedule and changes in living costs, although it has lagged behind increases in the OMA's fee schedule.

When the Ontario government took over insurance for medical services in 1971, the negotiated fee schedule was set at 90 per cent of the then OMA list of fees. The reduced rate was seen as reasonable given that at least 10 per cent of physicians bills went uncollected under the private system which had previously existed.

Adjusing the OHIP fee schedule to reflect 90 per cent of the OMA schedule, produced a 10 per cent decline in the value of the fee schedule relative to consumer prices prior to 1975. Even accounting for this however, the OHIP fee schedule declined nearly 8 per cent relative to the cost of living during this period. It also lost considerable ground against the dental association fee schedule in the 1970 to 1975 period.

In the decade since 1975 however, the OHIP fee schedule has increased by 138 per cent as compared with 121 per cent for dental fees and 118 for the cost of living. The OMA fee schedule has grown by 180 per cent in the last ten years. Since 1970, the OHIP fee schedule has increased slightly less than that of the dental association. Further, it has also kept pace with changes in living costs if the adjustment to 90 per cent of the OMA

Table 1

COMPARISON OF PERCENTAGE INCREASES IN PROFESSIONAL TARIFFS

Year	Ontario Dental Association	Ontario Health Insurance Plan	Ontario Medical Association	Consumer Price Index
1971	7.1	4.5	4.5	1.6
1972	-	-	-	4.9
1973	6.7	-	-	7.9
1974	6.3	7.8	7.8	10.5
1975	17.7	4.0	4.0	10.7
1976	10.0	8.1	8.1	7.3
1977	1.8	6.5	6.5	7.7
1978	6.0	6.3	36.3	8.5
1979	6.0	6.6	6.9	9.3
1980	10.0	11.5	11.9	10.1
1981	7.9	14.8	13.9	12.5
1982	11.1	11.0	13.0	11.3
1983	6.5	12.0	7.7	6.1
1984	5.9	8.2	3.2	4.8
1985	5.6	6.1	4.2	3.8
Cumulative:				
1970 - 1985	182.5	179.2	227.8	206.8
1975 - 1985	121.0	138.4	179.7	118.0

Source: Adapted from a table appearing in "An Economic Analysis of the Ontario Legal Aid Tariff" (May, 1985) Canadian Bar Association - Ontario, Legal Aid Committee.

schedule is included. On the other hand, the OMA fee schedule has grown at a much faster rate than other fee schedules or living costs.

A review of income data across major professions reveals that physicians have remained the highest paid professional group throughout the last twenty years. Adjusting for inflation, doctors in Ontario earned, on average, 15 per cent more in 1983 than they did in 1965. Several other professional groups, notably architects, engineers and lawyers have actually lost ground to inflation in recent years.

The Social Planning Council therefore concludes that the large disparity which currently exists between the OHIP and OMA fee schedules does not reflect inadequate fee levels within the negotiated schedule. We believe that the level of remuneration provided through the OHIP fee schedule has not eroded the average incomes of physicians relative to other professional groups. Further, since OHIP fee increases have consistently exceeded inflation in recent years a sufficient margin exists within these increases to make any necessary adjustments relating to inequities among physicians.

Specific Comments On The Legislation

Recent discussion in the media and elsewhere has raised the possibility of amending the legislation to permit physicians who choose not to participate in the plan to bill patients at above OHIP rates modelled on the practice in Quebec and Saskatchewan. The Social Planning Council strongly endorses the complete ban on extra-billing as proposed in Bill 94. We feel the potential risks of such an amendment would far outweigh the benefits.

The legislation continues to provide for practitioner choice in that physicians can either bill OHIP or direct bill their patients. While supporting practitioner choice, the Council believes that direct-billing at the time that service is received acts as a deterrant to the receipt of timely and appropriate health services. We recommend that patients not be required to pay medical bills until they have been reimbursed by the health insurance plan.

The section of the legislation dealing with penalties for contravention specifies a maximum fine of $10,000 for each offence, but leaves the onus on the patient and the crown to ask for repayment of the amount extra-billed which is left at the discretion of the judge. The Social Planning Council believes that the legislation should provide for both a maximum and minimum fine, and that the court should in all cases order the physician to reimburse the amount by which the patient was over charged.

The legislation is weakened by its failure to adequately address the need for an equitable, impartial and publicly accountable method of resolving disputes. While affording medical practitioners significant input both in the design of the collective bargaining process and in determining the items to be bargained, the legislation leaves unclear the mechanisms for resolving disputes should an impasse develop.

The Social Planning Council concurs with the viewpoint articulated by the Ontario Health Coalition that the negotiating process must conform to established principles of collective bargaining, must possess procedural equity, and that agreements once reached must be binding on both parties.

Where matters can not be resolved through conciliation or mediation, binding arbitration should be provided for. The mechanisms for dispute resolution including a procedure for binding arbitration should be included in the legislation.

The Next Step: An End To Premiums

The Social Planning Council supports this important piece of legislation to do away with the practice of extra-billing once and for all. With this issue finally behind us, it is our hope that attention can then be focussed on the many other critical issues facing our health system. As an immediate next step, we call on the government of Ontario to eliminate OHIP premiums.

This Council has consistently opposed health insurance premiums as a very regressive tax which places an unfair burden on many individuals and families of modest means. Some families living as much as 30 per cent below the poverty line are required to pay full premiums. They pay the same amount in premiums as families earning two, three or ten times their income.

While some low-income households are eligible for full or partial premium assistance, many simply fail to apply. Further, Ontario's premium system raises questions as to whether Ontario meets the universality of coverage provisions under the Canada Health Act. The government has been examining alternative ways of raising the roughly $1.6 billion in revenues it collects through premiums since 1981.

Several other provinces raise some portion of health care revenues through a payroll tax or a surtax on higher income individuals and corporations. It is time for Ontario to act to eliminate this regressive and unfair tax, and to devise a means of raising these funds on a progressive basis.

We thank the Committee for its time and attention.

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